SUMMARY PLAN DESCRIPTION

FOR THE NEW YORK POST CAFETERIA PLAN FOR PRINTING PRESSMEN UNION NO. 2 – REPRESENTED EMPLOYEES

Effective as of September 15, 2004

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INTRODUCTION

We are pleased to provide you with the Summary Plan Description for The New York Post Cafeteria Plan for Printing Pressmen Union No. 2 – Represented Employees (the "Plan"). This booklet is required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). We urge you to read it carefully.

The Plan provides eligible employees with an opportunity to pay for welfare benefits received from the Pressmen's-Publishers' Welfare Fund (the "Fund") through payroll deductions, which are then transferred to the Fund by The New York Post (the "Employer" or "the Post"). Federal income tax, and in most states, State income tax, is deferred on participants' contributions made on a Pre-Tax basis. **Please note that if you have a claim for any benefits provided under the Fund, you should contact the Fund for the proper claim procedures.**

This Summary Plan Description briefly describes the Plan in easy-to-understand language.

THIS IS A SUMMARY OF THE PLAN, NOT THE LEGAL PLAN DOCUMENT. IT IS INTENDED TO DESCRIBE THE PLAN ACCURATELY, BUT IN CASE OF ANY DISCREPANCIES BETWEEN THIS SUMMARY PLAN DESCRIPTION AND THE ACTUAL PLAN DOCUMENT, THE PLAN DOCUMENT WILL GOVERN.

A copy of the Plan is available for you to review, upon request, during business hours. If you would like a copy of the Plan, a reasonable charge will be imposed. Please contact the Human Resources Department and consult the full Plan if you have any questions regarding your rights and benefits.

PARTICIPATION

ELIGIBILITY

You are eligible to participate in the Plan if you are employed by the Post and your employment is covered by a collective bargaining agreement with the New York Newspaper Printing Pressmen Union No. 2.

ENROLLMENT

The Plan year runs from January 1 to December 31 each year. If you are eligible, you may enroll in the Plan within 30 calendar days of the effective date of this Plan, within 30 calendar days after meeting the eligibility requirements or during the open enrollment period prior to the start of a new Plan year.

To enroll, you must file an election form with the Plan Administrator within the appropriate time period. This election form will permit you to elect benefits under the Plan in an amount equal to the employee contribution for the chosen coverage under the Fund for the plan year and authorize a reduction in your paychecks over the plan year equal to the election amount (the "Wage Reduction Amount"). You will be deemed to have elected to receive a cash benefit equal

to the amount of your wages that would be paid to you for a plan year if you do not make an election to make the employee contribution to and receive benefits under the Plan (the "Cash Benefit").

After your initial enrollment in the Plan, your enrollment in the Fund each year will automatically extend your enrollment in the Plan.

CHANGES TO PARTICIPATION

Generally, once you choose whether to enroll in the Plan, you may not make changes during the calendar year. The Plan provides four instances in which you may make changes to your participation in the Plan during the year.

1. Change in Family Status

A change in family status is a change in any one of the following:

- Legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment;
- Number of dependents, including birth, death, adoption, and placement for adoption;
- Employment status of the Participant or Participant's spouse, including termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, change from full-time to part-time status or vice versa, and a change in worksite;
- Dependent satisfies or ceases to satisfy eligibility requirements, including attainment of age or student status; or
- Place of residence.

If you have a change in family status, and that change affects eligibility for coverage under the Fund, then you may change your election under the Plan accordingly, effective as of the first day of the payroll period following the date of the change in status.

2. Loss of Coverage

A loss of coverage occurs when an eligible employee or his dependent who had coverage under a group health plan or health insurance coverage at the time of the employee's election to participate under the Plan and (1) the individual's coverage was under a COBRA continuation provision and the coverage was exhausted or (2) the individual's coverage was not under a COBRA continuation provision and the coverage terminated either as a result of loss of eligibility for coverage or employer contributions towards the other coverage have been terminated. If you have a loss of coverage, you may elect benefits under the Fund no later than 30 days after the date of the loss of coverage. If you elect these benefits after a loss of coverage, you may also make an election to participate in the Plan, which will be effective not later than

the first day of the first calendar month after the election form is received by the Plan Administrator.

3. Acquisition of Dependent

An acquisition of dependent occurs when a person becomes a dependent of an eligible employee through marriage, birth, adoption or placement for adoption. Upon the acquisition of a dependent, you may elect benefits under the Fund within 30 days after the date of the event that results in the acquisition of a dependent. If you elect such benefits, your election to participate in the Plan will be effective, in the case of marriage, on the first day of the first calendar month after the election form is received by the Plan Administrator and in the case of a birth, adoption or placement for adoption, the date of such event.

4. Change in Entitlement to Medicare or Medicaid; Significant Cost or Coverage Change

A change in entitlement to Medicare or Medicaid means that you, your spouse or dependent becomes entitled to or loses eligibility for coverage under Medicare or Medicaid. A significant cost or coverage change occurs when there is:

- A significant increase or decrease in the amount of your contributions required to receive benefits under the Fund for you and your eligible dependents;
- A significant curtailment of your benefits under the Fund;
- The benefits available under the Fund are amended to add a new benefit package option or other coverage option or to significantly improve an existing benefit package option or other coverage option;
- A change in coverage under another employer plan; or
- A loss of coverage under other group plan coverage.

If there is either a change in entitlement to Medicare or Medicaid, or there is a significant cost or coverage change, you may change your participation effective the first day of the payroll period following this change.

All changes in participation must be approved by the Human Resources Department to become effective. You will be required to provide appropriate documentation to prove the event. All requested changes are reviewed on an individual basis.

BENEFITS

AMOUNT OF BENEFITS

If you file an election form with the Plan Administrator, the Wage Reduction Amount cannot exceed the amount of your employee contributions for coverage under the Fund for the plan year.

PAYMENT OF BENEFITS

Payments of the employee contributions by the Employer under the Plan for the participant's coverage under the Fund will be made directly by the Post from the Post's general assets. Separate funding for these employee contributions will not be made under the Plan in advance. If you do not have a valid election for a Wage Reduction Amount, you will receive a Cash Benefit in the same manner as your regular wages.

The employee contributions to receive coverage under the Fund will be paid by the Post as level regular payments in the amount of the Wage Reduction Amount. Your wages will be reduced in uniform amounts for each payroll period during the plan year to reflect the applicable election amount. The Plan Administrator may waive this requirement for uniform reductions throughout the year if you have a change in your participation during the plan year or the reductions already equal the total election amount or the amount to be contributed to the Fund changes.

CLAIMS FOR BENEFITS

All initial and disputed claims for benefits under the Plan should be submitted to a person designated by the Plan Administrator to handle claims (the "Claims Administrator"). The Claims Administrator will decide within 90 days after receiving the claim from a Participant or beneficiary ("Claimant"), or his authorized representative. **Please note that this claims procedure is not applicable to claims for any benefits provided under the Fund and that the Fund should be contacted to determine the proper procedures in that case.**

If the Claims Administrator decides that an extension of time for processing is required, written or electronic notification of the extension will be furnished to the Claimant before the initial 90-day period ends. The extension will never be longer than 90 days from the end of the initial period. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Claims Administrator expects to render the benefit determination.

The time period in which the Claims Administrator must make the benefit determination will start as soon the claim is filed in accordance with these claim procedures, regardless of whether all the information necessary to make the benefit determination accompanies the filing.

If the claim is denied in part or in full, written or electronic notice of denial will be sent to the Claimant or his authorized representative. The written or electronic notice will include:

- the specific reason or reasons for the denial;
- specific references to pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the Claimant to perfect the claim, and an explanation of why such material or information is necessary; and
- an explanation of the Plan's claim review procedures and the time limits applicable to such procedures including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

Within 60 days after the denial of a claim, the Claimant, or his authorized representative, may appeal, in writing, the denial of the claim to the group of two or more persons designated by the Plan Administrator (the "Committee") and request a review. In connection with the review, the Claimant or his authorized representative may review pertinent documents and may submit issues and comments in writing. Upon request, the Claimant will be provided reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits free of charge. The review will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claims, without regard to whether this information was submitted or considered in the initial benefit determination.

The Committee will deliver the decision on review, in writing or electronic means, to the Claimant or his authorized representative within 60 days after receiving the review request, unless there are special circumstances (such as the Committee deeming it necessary to hold a hearing), which require extensions of time for processing. If the Committee determines that an extension of time for processing is required, written or electronic notification of the extension will be furnished to the Claimant before the end of the initial 60-day period. The extension will never be longer than 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Committee expects to render the determination on review.

The time period in which a benefit determination on review must be made will start as soon as the appeal is filed in accordance with these claim procedures, regardless of whether all the information necessary to make the benefit determination on review accompanies the filing. If the time period is extended because the Claimant failed to submit information necessary to decide the claim, the period for making the benefit determination on review will be suspended from the date on which the extension notification is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

In the case of an adverse benefit determination on review, the Committee will provide access to, and copies of all documents, records, and other information relevant to the Claimant's claim for benefits.

The decision will be sent in writing or by electronic means and include:

- the specific reason or reasons for the denial;
- specific reference to pertinent Plan provisions on which the denial is based;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits; and
- a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA.

The Claims Administrator will have the discretionary and sole and absolute authority to make decisions on claims (where no review is requested). The Committee will have the discretionary and sole and absolute authority to make decisions on review (where review is requested).

Decisions of the Claims Administrator (where no review is requested) and Committee (where review is requested) will be binding and conclusive on all interested persons as to participation, benefit eligibility and benefits and any other matter of fact or interpretation relating to the Plan.

OTHER INFORMATION YOU SHOULD KNOW

PLAN CONTACT INFORMATION

The Name of the Plan
The New York Post Cafeteria Plan for Printing Pressmen Union No. 2 – Represented Employees

Name and Address of Company and Sponsor of the Plan
The New York Post
1211 Avenue of the Americas
New York, NY 10036-8790
(212) 930-8000

Employer Identification Number
13-3732753

Plan Number
501

Type of Plan
Cafeteria plan under section 125 of the Code

Type of Administration
Self-administration

Claims Fiduciary and Plan Administrator
The New York Post
1211 Avenue of the Americas
New York, NY 10036-8790
Telephone: (212) 930-8000

Agent for Service of Legal Process
The New York Post
1211 Avenue of the Americas
New York, NY 10036-8790
Telephone: (212) 930-8000

Plan Year
January 1 to December 31

Source of Contributions
Employee

THE FUTURE OF THE PLAN

The Company expects and intends to continue the Plan in the future, but reserves the right to terminate, amend, or modify this Plan at any time for any reason. If the Plan is changed or terminated, any changes in your coverage, participation or benefits will be in accordance with applicable law.

ERISA INFORMATION

As a participant in The New York Post Cafeteria Plan for Printing Pressmen Union No. 2 – Represented Employees, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

- Receive information about their plan and benefits
- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision

or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in
Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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